

HB 4 (Formerly HB 692) Working Group on the Plan Preparation of a Medicaid Adult Dental Benefit

February 13, 2020
Minutes

Working Group Members Present: Henry Lipman, Dr. Sarah Finne, Mike Auerbach, Lisa Beaudoin, Erica Bodwell, Gail Brown, Shirley Iacopino, Courtney Morin, Dr. Kelly Perry, and Alexandra Sosnowski

Working Group Members Attending by Phone: Dr. Kris Blackwelder, Laural Dillon, Joan Fitzgerald, Joanne Fontana, Dr. Daniel Kana, Nicole Tower, and Ed Shanshala (Call was recorded)

Materials distributed via email:

- Handout: NH Medicaid SFY 2018 Enrollment, Non-ED dental expense, and ED dental expense
- Handout: SFY 18 NH Medicaid Non-Dental Non-ED Claims Analysis

Following introductions, Dr. Sarah Finne (Medicaid Dental Director) brought the meeting to order.

Updates

GPR/HRSA Grant:

The deadline to submit the HRSA grant application to establish a NH general practice dental residency program was February 12, 2020. Dr. Finne described the application as being very competitive. The accompanying letters of support illustrated well how critical a residency program would be for the State of New Hampshire. Application result notifications are not expected until June or July. Mike Auerbach requested a copy of the grant for ADA support.

Webpage:

Direct links to the [Dental Quality Alliance \(DQA\)](#) and the [National Committee for Quality Assurance \(NCQA\)](#) have been added to the HB 4 Working Group, Supporting Documents webpage for those interested in learning what is going on in the world regarding quality measures. DQA deals with dental measures. NCQA has a few different measures. NCQA posted a notice that they are considering retirement of one of their dental measures. In response to a question from Erica Bodwell, Sarah Finne explained that the NCQA measure considered for retirement measures any dental visit during the course of a year for children age 0-20. NCQA realizes this is an “access” measure rather than a quality measure. If NCQA decides to retire the question, it would not happen until 2022. NCQA would come up with an alternative measure. The Oral Health Technical Assistance Group (OTAG) a CMS led group, would have someone from NCQA on the March call to discuss this. At some point, Dr. Finne will have more information to share on this.

Dr. Finne updated the [Detailed Dental Benefit/Plan Description](#) document based on input from the Working Group’s January 16th meeting. Please review the document to make sure nothing was missed or whether there is something else that should be included.

Other information

Erica Bodwell informed the group that Senator Rosenwald submitted legislation that has not yet been printed or assigned a bill number. Northeast Delta Dental had a legislative reception on

February 12, 2020, attended by Governor Sununu who made very positive comments about an adult dental benefit, going so far as to call the benefit “a top priority,” according to Mike Auerbach.

Erica Bodwell clarified that Northeast Delta Dental estimates are based on total costs. Henry Lipman was encouraged that estimates from Northeast Delta Dental and Milliman are “in the same universe.” He has an understanding that submitting a range of figures for the legislation will suffice since the benefit has not yet been “nailed-down”. If the fee schedule is changed, the children’s fee schedule and benefit estimates will have to be adjusted.

Erica Bodwell clarified that Northeast Delta Dental does not have a transportation program, so their estimates do not include transportation costs. Pharmacy costs will be included in the next layer of cost estimates. Medical offset costs will not be initially used; need to ramp-up to realize cost savings and Year 1 utilization is unknown.

NH Medicaid SFY 2018 Enrollment, Non-ED dental expense, and ED dental expense (handout review): The document contains more precise population numbers. The last three age groups 65-85 and over, are “dual-eligibles” and are included in the benefit at a standard FMAP (50%).

Age Grp	Claim Type = Dental	Claim Type = Facility/Professional		Any Claim Type	Claim Type = Facility/Professional	SFY 2018 Unique Member Population	SFY 2018 Member Months
	Dental Claim Amt	Medical Claim Exclude trauma Non-ED Amt	ED (Excl Trauma) Amt	Count of Members w Any Dental Related Service (Excl Trauma)	Count of Members w a Non-Dental Claim (Excl Trauma)		
Ages 21 to 44	\$ 1,729,853.18	\$ 749,044.79	\$ 882,511.29	7,979	3,860	72,991	636,433
Ages 45 to 64	\$ 747,623.60	\$ 501,994.62	\$ 209,541.84	3,264	1,321	39,766	357,821
Ages 65 to 74	\$ 57,713.00	\$ 125,889.95	\$ 14,990.89	345	136	5,122	47,310
Ages 75 to 84	\$ 20,277.50	\$ 3,584.60	\$ 1,808.56	125	50	3,628	32,991
Ages 85 and over	\$ 6,182.00	\$ 11,688.36	\$ 874.52	63	46	3,968	35,393
Total	\$ 2,561,649.28	\$ 1,392,202.32	\$ 1,109,727.10	11,776	5,413	125,475	1,109,948

First column after the age group is actual dental claims through Medicaid fee for service (extractions, exams, and x-rays) dentist billed in any setting.

Alexandra Sosnowski noted that in Maine it was useful to break down the costs to what is covered in the state plan. For instance, \$0.0 preventive care, \$?? for treatment of pain and infection, \$?? Extraction, etc.

Second column after the age group are medical claims that list a primary dental diagnosis code. This includes hospital stays where the patients presented through the ED and became an inpatient; medically frail adults who need to be treated in the hospital; and dental infection requiring IV antibiotics, to mention a few. Dr. Finne acknowledges she needs to dive deeper on many of these costs. The costs listed include physician and facility costs.

Third column after the age group is actual ED charges with trauma excluded. Dental trauma is a small item – maybe \$100K.

Erica Bodwell suggested that listing the “state paid” amount would be useful. She also asked if the ED costs were the same as those used by Milliman. Dr. Finne said no, but that Milliman would be updating their data.

Dr. Perry asked if there was a way from claims data of telling the time of day that an ED visit occurred; or if there is a way to identify repeat visits.

SFY 18 NH Medicaid Non-Dental Non-ED Claims Analysis (handout review):

Top table is a breakdown by dental diagnostic code presenting in a medical setting. 99213/99214 are for established patients. It is not known whether they are repeating for a dental visit.

Second Table is for “other” claims from ambulatory or hospital surgical centers (anesthesia, recovery room and surgical supplies and devices).

Third Table presents more specific outpatient dental claims such as excision of tumors. These are needed services, so savings will not be realized in this category.

Finally, inpatient or nursing facility dental claims. Dr. Finne will look at these claims in detail.

Erica Bodwell: How should we be talking about this? How will savings be realized?

Henry Lipman: Rates are set on the medical side based on experience. We need to identify key markers on the medical side where we would expect improvement for example, in systemic infection and cardiac valve disease – a use rate per thousand. This will not show up immediately.

HRSA Funded Care Coordination Pilot Project (*Laural Dillon presenting*)

Laural Dillon presented information on a HRSA funded project entitled, “Strengthening the Oral Health Workforce Capacity to Prevent and Control Opioid Misuse in New Hampshire.” There are several components to this project; one being a care coordination pilot project that may be of interest to the working group.

The purpose of the care coordination component is to decrease the number of patients utilizing the ED for NTDCs, increasing the number of adults who have access to dental care, decreasing the number of opioid prescriptions given to patients with dental pain, and improving health system integration. We know many people lack access to care coordination services that would improve their access to dental treatment after visiting the ED for non-traumatic dental conditions, and this is because many hospitals do not have established relationships or a referral process in place with dental providers willing to accept patients referred from the ED.

After looking at hospital data, we determined that Alice Peck Day (APD) had the highest percentage of total ED visits for NTDCs statewide in 2017. Once we reviewed that data, we knew that Mascoma Community Health Center (MCHC) is the closest in proximity to APD. MCHC also provides dental care, so we decided MCHC would be the best organizations to partner with on this project. We approached APD and MCHC with our project proposal to plan, implement, and evaluate the impact and cost-effectiveness of a dental care coordination program, and they are both willing and excited to become partners. Although the project has not officially started, we have had a few preliminary meetings with both organizations. It was decided it would be helpful, as we develop this pilot, to survey patients who present to the ED for NTDCs to better understand: specific barriers patients are facing when trying to access dental care in this area; their unmet dental needs are; their reasons for not visiting a dentist; how long it has been since their last visit to the dentist for preventive care; insurance status; as well as other questions.

We realize that this model is not sustainable without reimbursement for adult dental services, but want to show the impact that care coordination could have in increasing access to care and addressing barriers, as well as the cost-effectiveness of having a care coordination model.

Laural Dillon shared the survey results:

1. How many visits to the ED in the past 12 months?
 - Never
 - 1 time-14 **70%**
 - 2-3 times-6 **30%**
 - 4 or more

2. Unmet dental needs
 - Tooth pain (hot, cold, chewing)-15 **75%**
 - Infection-15 **75%**
 - Cavities-7 **35%**
 - TMJ pain-2 **10%**
 - Missing teeth-6 **30%**
 - Missing/broken fillings-8 **40%**
 - Denture/partial not fitting well
 - Swollen gums-7 **35%**

3. Reasons for not visiting the dentist
 - Cost-10 **50%**
 - Lack of insurance-8 **40%**
 - Fear-3 **15%**
 - Can't find a dentist who accepts my insurance-5 **50%**
 - Office hours don't work with my schedule-1 **5%**
 - Other-2 10%

4. Last visit to the dentist for preventive care
 - 0-6 months-2 **10%**
 - 6-12 months-3 **15%**
 - 1-3 years-3 **15%**
 - More than 3 years-11 55%

5. Insurance status
 - No, I don't have a dental plan-9 **45%**
 - Yes, I have Medicaid which doesn't cover dental cleanings or fillings-7 **35%**
 - Yes, I have Private/commercial dental plan-3 15%

The oral health program plans to hire a project coordinator who would will at MCHC.

Gail Brown suggested that it would be valuable for the new coordinator to meet with Tanner Wallace, DMD, the lead for the NHDS Grafton-Sullivan component.

Michael Auerbach offered to facilitate this meeting. NHDS also partners with the Vermont Dental Society since people cross the border.

Dr. Blackwelder: How and where are uninsured patients being connect to an oral surgeon or to a general dentist?

Laural Dillon: This project is only for APD ED patients and services will be provided at MCHC.

Ed Shanshala commented that this work is interesting and important. Ammonoosuc Community Health Services (ACHS) has been accepting patients from the Littleton Regional Hospital ED for

at least 5 years. If a patient presents in the ED, ED staff know they can contact ACHS for dental care during regular hours. ACHS has not analyzed the data, so he does not know whether a patient who was previously sent to ACHS for an urgent dental extraction and has another urgent dental need presents again at the ED or goes directly to ACHS. He also noted that patients presenting at the ED have varying stages of readiness for dental care. This must be accounted for because no-show rates can be as high as 50%. Need to be mindful to work with patients at different stages of readiness so we move away from extraction to prevention.

PARKING LOT ITEM: Think about how to help patients in becoming more comfortable in getting the care they need.

Dr. Finne: Oral Health literacy – debunking years and years of stories that cause fears. There are several ways to address this issue.

Other Comments

Michael Auerbach: NHDS has nine components grouped by geography. Need to look at data by county.

Dr. Blackwelder: NHDS conducted a survey and captured some data on donated services.

Ed Shanshala: Patient presents, if they are Medicaid-able, we submit payment. If there is additional work not currently covered by Medicaid and their income is less than 200% of the federal poverty level, we use a sliding fee scale discount.

Ed Shanshala: ACHS can provide VPN access to HIPAA compliant data to search and obtain a sense of the patients that ACHS sees (1K a year).

Joan Fitzgerald: Important to build infrastructure to move into outcomes.

Mike Auerbach: Having a professional who is trained in care coordination as well as navigation.

Gail Brown: What is it that the dentist wants to know before seeing a patient? Not a one-size answer. Are there core requirements for care coordination?

Dr. Finne: There is a core element; need to know the system; the health centers and non-profit dentists. Need to know things like does this person need 3 extractions in the next few days; or has 17 cavities.

Michael Auerbach: He has been talking to groups to coordinate CHWs. CHWs are regionally fluent. NHDS staff does a lot of care coordination. Don't know what the patient's exact needs are since we are dealing with issues that are self-diagnosed.

Erica Bodwell: After digging into cost and we figure it out, are we going to do a deep dive into the network?

Housekeeping

- Dr. Finne asked if the meeting time, 4 to 6 pm, is working for participants? Participants thought it worked better.
- Meeting ended at 5:15pm.
- Next meeting Thursday, February 27, 2020, 4:00 – 6:00 PM
NH Department of Health and Human Services
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